STANDARDIZING HEALTH INSURANCE CONTRACTS
EXECUTIVE SUMMARY

HEALTH INSURANCE CONTRACTS

Health insurance contracts are inherently complex and difficult to interpret. The complexity of coverage contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance.

Complexity offers insurers opportunities to exercise cost-increasing strategies that are beneficial to the insurers, but not to consumers, including: (1) product differentiation that makes comparisons difficult, reduces price-elasticity of demand which decreases the incentive for health plans to offer lower prices, and raises switching costs by making it more expensive for a consumer to switch plans; (2) market segmentation that limits competition by dividing customers into groups by product design; (3) risk selection by designing products that are unattractive to high risk persons; and (4) coverage exclusions, hidden in the fine print.

STANDARDIZATION TO SIMPLIFY, PROTECT, AND REDUCE COSTS

To protect consumers, major purchasers have standardized coverage contracts. In order to offer both HMOs and PPOs, contracts vary with respect to cost-sharing. However, a standardization policy can seek to make contracts as similar as possible. Doing so will increase understanding, reduce administrative costs, and facilitate comparisons.

Implementation of standardization has proved difficult. Despite its challenges, standardization has worked successfully for major purchasers in California. However, while large employers and employer coalitions have the resources to protect their members adequately without assistance from regulators, small groups and individuals need help.

Recently, Congress passed a law that only approved reference packages could be sold in the Medi-Gap market for supplemental Medicare insurance. Indications so far are that this market is now working much better for consumers.

Concerns Regarding Standardization

Standardization has been criticized as denying people choice of product features. However, due to the potential for risk selection (e.g., only AIDS patients want coverage for AIDS drugs), this argument is not valid. Whole groups must make a decision as to whether or not they want a particular type of coverage, and if it does, it must apply this standard uniformly to all plans.

Standardization need only apply within sponsored groups, not among them. Furthermore, controlled departures from complete standardization are possible.

Standardization Options

There is a continuum of pro-standardization policies that the State could adopt. From the most prescriptive to the least, they include:

- A uniform, national contract, as is the case of Medicare.
- A "Medi-Gap" solution. This would involve a set of standard coverage options and a requirement that, at least in certain markets (e.g., small group market), insurers offer only those products.
- A set of "endorsed reference packages", probably with approved variations such as more or less cost-sharing, designed with the participation of small employer associations and the HIPC, and reviewed and approved by the Department of Corporations. Health plans would be able to offer the endorsed reference packages without further review, rather than seeking approval for each product.

TASK FORCE FINDINGS AND RECOMMENDATIONS

Non-standard coverage contracts add to transactions costs, help to segment markets, and make demand price-inelastic thus raising prices to purchasers and consumers. Market efficiency can be enhanced by standardization within large groups and by making endorsed standard reference contracts available for use in the small group and individual market.

The Governor should direct the Department of Corporations to adopt a positive stance toward the development of standard reference coverage contracts that can be used by buyers and sellers by reference, that health plans can offer without new approvals in each case.

In addition, the DOC should work with the HIPC, small business associations, and other small group purchasing organizations to develop a set of 10 or more standard reference packages or contracts, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices. Small business would not be required to limit its choices to these standard packages and even could take the initiative to develop new ones. But, in effect, Department of Corporations approval for the standard packages would be "fast tracked", and the market could be expected to evolve increasingly around the standard reference packages.

STANDARDIZING HEALTH INSURANCE CONTRACTS

I. HEALTH INSURANCE CONTRACTS

A health insurance contract consists of a list of covered services (i.e., services that will be paid for in whole or in part by the insurer) such as preventive services, physician services, etc. Covered services are subject to a schedule of deductibles, coinsurance and copayments, to limitations such as 30 days per year for inpatient mental health, to exclusions such as of medically unnecessary services, experimental or investigational therapies, and certain procedures. In managed care, covered services must be obtained from contracting providers, medical necessity is determined by the judgment of the participating physicians or the plan's medical director, and in many cases must be approved in advance of treatment, and, in response to the demands of payors for cost containment, exclusions of unnecessary and investigational services are enforced.

A. Inherent Complexity

Health insurance contracts are extremely complex and difficult to interpret, even by experts. This is inherent in the nature of the subject and not necessarily the result of any deliberate action on the part of insurers. Evidence of Coverage documents are so over-burdened by regulatory disclosure requirements that finding relevant information can be a difficult task.

Even "simplified" presentations of health insurance contracts are not easy to understand. For example, the simple summary of California Public Employees Retirement System (CalPERS) covered benefits takes 45 lines to describe one plan. Previously, when each CalPERS health plan contract was different, understanding the alternatives would require mastery of about 1000 items. Much of the important distinctions occur in the fine print which is even more complex. Furthermore, people typically do not read their health insurance contracts until they need care, and they often can not appreciate the subtle differences in the meaning of important terms until they have experienced a problem.

There is no clear, agreed-upon definition of "medical necessity", and the frequency of many medical procedures per capita varies five-fold among different communities suggesting a wide range of different opinions as to what is medically appropriate.[1] There is also no agreed or clear standard for what is "experimental". In a nation populated by creative, innovative, entrepreneurial doctors who invent new treatments and advocate them persuasively, there is much room for disagreement as to what is a "proven" technology, and standards of proof are evolving.

The complexity of coverage contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance. Rather, the most promising method for achieving a satisfactory contract involves a large group that purchases a specified coverage contract, armed with the professional advice it can afford, and that

[1] John Wennberg, *The Dartmouth Atlas of Health Care*, Chicago: American Hospital Association, 1996.

negotiates revisions based on the aggregate experience of the group as unsatisfactory provisions appear.

B. Insurance Strategies Based on Complexity

Complexity also offers insurers opportunities to exercise strategies that promote their economic advantage at the expense of consumers. Some of these strategies have been major contributors to the explosive increase in price of health care coverage.

First, insurers can differentiate their product from others by offering a combination of features unlike those offered by any other carriers. This makes it very difficult for the customer to understand the differences and to make "apples versus apples" comparisons. This strategy shifts attention from price to features. By decreasing the ability of individuals to compare plans, product differentiation decreases the "price-elasticity of demand" which decreases the incentive for health plans to offer lower prices. Product differentiation raises "switching costs" by making it more "expensive" for a consumer to switch from one plan to another in the hope of saving money. Who can afford to devote the days of his life needed to understand the differences among policies in the hope a smart choice might save $200 per year. Some people rely on experts (agents, brokers and consultants) for advice, but these experts have their own economic interests and biases.

Second, insurers can segment markets by offering product designs that can divide customers into separate groups according to the product design they choose, limiting competition for the same customers. An example of this occurred at Stanford University in the 1970s. Employees were offered a choice of Kaiser Permanente that, as part of its benefit package, covered all the costs of medical services for pregnancy and delivery and a Palo Alto Medical Clinic (PAMC) prepaid plan that did not cover such costs. The result, as could have been expected, was that those who were planning or expecting babies more often chose Kaiser, while those who were not, more often chose PAMC. In this instance, the two health plans were not in head-to-head competition for the same customers.

Market segmentation is a time-honored business strategy for raising profit margins and reducing competition. Market segmentation is particularly important in the case of managed care plans because the typical community will only be able to support several managed care plans and because there are many variables that can be used to segment markets.

Third, insurers can design coverage contracts to select risks. There are literally endless ways in which health insurance contracts can be designed to make them unattractive to people with above average health risks, including higher deductibles and coinsurance, limits on benefits, and exclusions from coverage (refer also to Task Force paper on Risk Adjustment: A Cure for Adverse Selection).

Fourth, insurers can cut costs by including in coverage contracts tricky exclusions, hidden in obscure language in the fine print. In the early 1990s when CalPERS

embarked on an effort to standardize its coverage contracts, they discovered that one plan that covered organ transplants in the bold print excluded coverage of the expenses of harvesting and transporting the organ in the fine print, obviously making the transplant itself impossible. Until then, this provisions had escaped the expert staff at CalPERS.

II. STANDARDIZATION TO SIMPLIFY, PROTECT, AND REDUCE COSTS

Purchasers and consumer advocates must protect consumers in the face of these potential strategies. For the sake of equity and simplicity, purchasers should provide program participants with the same financial protection regardless of the plan they choose. To do so, major purchasers such as CalPERS, the University of California, Stanford, Pacific Business Group on Health (PBGH), the Health Insurance Plan of California (HIPC), and others have adopted the policy of standardizing the coverages they buy. Typically, they buy one standard contract for all health maintenance organizations (HMOs). Preferred provider organizations (PPOs), which pay providers a fee for service, must rely heavily on consumer cost-sharing since they do not have the ability of HMOs to control costs by putting providers at risk. Therefore, PPO contracts need to differ from HMO contracts with respect to cost-sharing, as is the case, for example, with CalPERS. Still, a standardization policy can seek to make contracts as similar as possible and different only where required. By standardizing the contract, management can have a much better chance of understanding what it is buying, administrative costs can be lower because staff in the benefits office need to learn only one contract, and participants can easily make comparisons among plans.

Given acceptance of the goal of standardization, one should not think that this policy is easily achieved. Implementation of standardization has proved difficult at the level of the fine print. Issues regarding definitions and exclusions will continue to challenge attempts to standardize until greater clinical agreement exists, as will limitations in our ability to detect and reduce practice variations across plans. Several California purchasers, including CalPERS and PBGH, have attempted or are attempting to reduce variation among coverage contracts at this level.

Despite its challenges, standardization has worked extremely successfully for major purchasers in California. It has created greatly increased price-elasticity of demand which is the most powerful antidote to excess health plan profit margins; it has simplified administration; and it has enhanced the bargaining power of purchasers such as CalPERS that must rely on bargaining. These purchasers would all affirm that standardization was an essential ingredient in bringing prices down. However, while large employers and employer coalitions have the resources to protect their members adequately without assistance from regulators, small groups and individuals need help.

An important recent case of standardization was action taken by Congress in the market for supplemental insurance for Medicare, called the “Medi-Gap” market. In the previously non-standardized market, consumers were confused, often bought wasteful,

overlapping coverage, and were not able to make economical choices.[2] In response, Congress asked the National Association of Insurance Commissioners (NAIC) to design a set of standard supplemental coverage contracts, from the barest to the most comprehensive, with the clear understanding that purchase of a more comprehensive coverage would obviate the need for a less comprehensive coverage. Then Congress passed a law that, starting in 1992, the only contracts allowed to be sold in the Medi-Gap market were those standard contracts. Indications so far are that this market is now working much better for consumers.[3]

A. Concerns Regarding Standardization

Standardization has been criticized as an example of "one size fits all thinking" and as denying people the choice of features they need and want. To understand why this argument is not valid, one must understand the special features of the health insurance market. Risk selection is always a major factor. If people want to buy a particular coverage feature, it is almost surely because they consider themselves to be more likely to use it.

Suppose some insureds say "I neither need nor want coverage of AIDS drugs". If Plan A decides to exclude coverage of AIDS drugs, it can be sure that it will not be chosen by AIDS patients, who will look elsewhere for coverage. This will put the other plans at a competitive disadvantage, which will force them to emulate Plan A or risk being driven from the marketplace. Under these circumstances, AIDS patients suffer. Whole groups must make a decision as to whether or not they want coverage of AIDS drugs, and if it does, it must apply this standard uniformly to all plans.

Standardization need only apply within sponsored groups, i.e., the set of people choosing among a set of plans; it does not need to apply among them, i.e., across employers purchasing separately. The principle of standardization does not imply that small business must have the same package as large employers. Furthermore, controlled departures from complete standardization are possible, for example with respect to cost-sharing, but must be balanced against the benefits of standardization, with special care not to select risks and segment markets.

B. Standardization Options

There is a continuum of pro-standardization policies that the State could adopt. From the most prescriptive to the least, they include:

- A uniform, national contract, as is the case of Medicare. Given the current political climate, there is no apparent support for this proposal at this time.
- A "Medi-Gap" solution. This would involve a set of standard coverage options and a requirement that, at least in certain markets (e.g., small group market), insurers offer only those products.

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[2] Select Committee on Aging, US House of Representatives, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal", Committee Pub. no. 95-160, Washington, DC: US Government Printing Office, 1978.

[3] Thomas Rice, et al., "The Impact of Policy Standardization on the Medigap Market", *Inquiry*, 34:2, Summer 1997, 106:116.

- A set of "endorsed reference packages", probably with approved variations such as more or less cost-sharing, designed with the participation of small employer associations and the HIPC, and reviewed and approved by the Department of Corporations. Health plans would be able to offer the endorsed reference packages without further review, rather than seeking approval for each product. Purchasers would have some standard reference points and could ask carriers or brokers for quotes for the reference package of their choice. Consumers could become familiar with reference packages and could have confidence in their coverage. Insurers might achieve greater legitimacy for their product offerings by using endorsed reference packages.

III. TASK FORCE FINDINGS AND RECOMMENDATIONS

Non-standard coverage contracts add to transactions costs, help to segment markets, and make demand price-inelastic thus raising prices to purchasers and consumers. Market efficiency can be enhanced by standardization within large groups and by making endorsed standard reference contracts available for use in the small group and individual market.

The Governor should direct the Department of Corporations to adopt a positive stance toward the development of standard reference coverage contracts that can be used by buyers and sellers by reference, that health plans can offer without new approvals in each case. Thus, for example, one or a few standard PBGH HMO benefit packages could be approved for use by all carriers serving PBGH members without further review and approval.

In addition, the Department of Corporations should work with the HIPC, small business associations, and other small group purchasing organizations to develop a set of 10 or more standard reference packages or contracts, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices. Small business would not be required to limit its choices to these standard packages and even could take the initiative to develop new ones. But, in effect, DOC approval for the standard packages would be "fast tracked", and the market could be expected to evolve increasingly around the standard reference packages.